

**NC DIVISION MH/DD/SAS
2011 MH/SA TARGETED CASE MANAGEMENT AUDIT**

PROVIDER NAME:			AUDIT DATE:	
ATTENDING #:		Billing #:	NAME:	
CONTROL #:			PROCEDURE CODE:	
MEDICAID #:			SERVICE TYPE:	
DOB/AGE:			BILLING DATE:	
RECORD #:			UNITS PAID:	
RATING CODES:	0 = No 2 = partially met 4 = Yes	6 = No service note 7 = Unable to identify service provider	8 = Repaid 9 = NA	RATING
AUTHORIZATIONS/SERVICE PLAN/ELIGIBILITY (Use rating of "4", "0" or "9" for Q 1-6)				
1. a. Is an authorization in place covering this date of service?				
b. If NO, list dates: FROM _____ TO _____				
2. a. Is there a valid service order for the service billed?				
b. If NO, list dates: FROM _____ TO _____				
3. a. Is the date of service covered by a valid PCP?				
b. If NO, list dates: FROM _____ TO _____				
4. Was a Comprehensive Clinical Assessment completed prior to providing the service?				
5. Was the individual eligible to initially receive services?				
6. Was the individual eligible for continuation of services?				
SERVICE DOCUMENTATION (Use Likert Scale See Instructions): Use rating of "4" or "0" for Q 7 and 12 (Use rating of "4", "2" or "0" for Q 8-11 — or ratings of 6, 8, or 9 as applicable)				
7. Does the service note(s) reflect a minimum of 15 minutes of service on or prior to the billing date?				
8. Is/are the service note(s) signed within the designated time frame by the person who delivered the service?				
9. Does the service note(s) relate to goals listed in the service plan (purpose of contact)?				
10. a. Does the service note(s) contain a description of an intervention?				
b. Does the service note(s) (intervention) relate to at least one of the four case management functions?				
11. Does the service note(s) contain a description of the results or outcome of the case management activity (ies)?				
12. Is there a service note(s) of a monthly face-to-face contact?				
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 13-15—or ratings of 7, 8 or 9 as applicable)				
13. a. Is there documentation that the staff is qualified to provide the service billed?				
b. If NO, list dates: FROM: _____ TO: _____				
14. a. Did the provider agency require disclosure of any criminal conviction by the staff person(s) who provided this service?				
b. If NO, list dates: FROM: _____ TO: _____				
15. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service?				
b. If NO, list dates: FROM: _____ TO: _____				
COMMENTS:				
AUDITOR:			LME:	